Dr. Randolph's Ageless & Wellness Medical Center

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FEMALE HEALTH HISTORY FORM

(Please Print Clearly)

Date: _____

Name: _____ DOB: _____

Reason for today's visit: _____

_____

Height:_____inches

Weight: Usual: _____ Recent Gain: _____ Recent Loss: _____

Allergies (check all that apply and indicate reaction)

- ☐ Aspirin_____
- ☐ Codeine_____
- ☐ Novocain_____
- ☐ Shellfish_____
- ☐ Betadine_____
- ☐ Latex_____
- ☐ Sulfa_____
- ☐ Other_____

Gynecological History

Age of menstrual period onset _____

Are you in menopause? ☐No ☐Yes

If No, please skip to Menstrual Information

At what age did your periods stop? _____

Have you had a hysterectomy? ☐No ☐Yes

If yes, when? _____

Do you have your ovaries? ☐No ☐Yes

Do you have a cervix? ☐No ☐Yes

Are you using Hormone Replacement Therapy?

☐No ☐Yes

If yes, what hormones are you replacing?

☐Progesterone

☐Estrogen

☐Testosterone

Explain_____

_____

_____

Menstrual Information

Date of last period_____

How long did it last? _____

Are your periods generally regular? ☐No ☐Yes

Do you bleed between periods? ☐No ☐Yes

Do you or did you ever have PMS? ☐No ☐Yes

Method of birth control used _____

Pregnancies

How many pregnancies have you had? _____

How many miscarriages? _____

How many children were born alive? _____

How many abortions? _____

How many tubal pregnancies? _____

Any complications with pregnancy? ☐No ☐Yes

Explain_____

_____

_____

Personal Medical History (check all that apply)

- ☐ Abnormal Pap Smears
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Gout
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Blurred Vision
- ☐ Bronchitis
- ☐ Cancer / type:_____
- ☐ Chest Pain
- ☐ Chicken Pox
- ☐ Chlamydia
- ☐ Colitis
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ FMS/CFS
- ☐ Gallbladder Disease
- ☐ Glaucoma/Eye Disease
- ☐ Gonorrhea
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Interstitial Cystitis
- ☐ Kidney/Bladder Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Mood Changes
- ☐ Mumps
- ☐ Pelvic Inflammatory Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Psychiatric Problems
- ☐ Redness/Pain in Leg
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Varicose Veins
- ☐ Venereal Warts
- ☐ Other _____
- ☐ Other_____

Surgical History (check all that apply)

- ☐ Appendix Operation Date: _____
- ☐ Breast Augmentation Date: _____
- ☐ Breast Biopsy Date: _____
- ☐ Bladder Surgery Date: _____
- ☐ C-Section Date: _____
- ☐ Coronary Artery Bypass Date: _____
- ☐ D&C Date: _____
- ☐ Endometrial Ablation Date: _____
- ☐ Gallbladder Operation Date: _____
- ☐ Hemorrhoid Operation Date: _____
- ☐ Hernia Operation Date: _____
- ☐ Hip Date: _____
- ☐ Hysterectomy Date: _____
- ☐ Laparoscopy Date: _____
- ☐ Plastic Surgery Date: _____
- ☐ Removal of Tube or Ovary Date: _____
- ☐ Thyroid Operation Date: _____
- ☐ Tonsillectomy Date: _____
- ☐ Tubal Ligation Date: _____
- ☐ Varicose Vein Operation Date: _____
- ☐ Other _____
- ☐ Other _____

Family History (check all that apply)

Does anyone in your immediate family – mother, father, siblings – have the following conditions(s):

- ☐ Breast Cancer _____
- ☐ Bleeding Disorders_____
- ☐ Cancer, other type_____
- ☐ Diabetes _____
- ☐ Fibrocystic Breast _____
- ☐ Heart Disease _____
- ☐ Osteoporosis _____
- ☐ Thyroid Disorder _____

Other _____ Explain _____
Other _____ Explain _____

Social History (check all that apply)

Do you drink caffeinated products? ☐No ☐Yes How many drinks per day/month? _____

Are you a smoker? ☐No ☐Yes Packs per day? _____Years smoked? _____

Are you a former smoker? ☐No ☐Yes Years smoked? _____Year quit?_____

Do you drink alcohol? ☐No ☐Yes How many drinks per day/month? _____

Do you exercise? ☐No ☐Yes How many times per week? _____ What type? _____

Do you use recreational drugs? ☐No ☐Yes

Medical Tests (check all that apply)

☐ Mammography Date: _____ Were the results normal? ☐No ☐Yes

If no what follow-up was needed?_____

☐ PAP Smear Date: _____ Were the results normal? ☐No ☐Yes

If no what follow-up was needed?_____

Have you ever had an abnormal pap? ☐No ☐Yes

If yes what follow-up was needed?_____

☐ Bone Density Date: _____ Results:_____

☐ Colonoscopy Date: _____ Results:_____

Are there any other pertinent medical history concerns we should be aware of?

_____

_____

Name of any physicians familiar with your medical history:

_____

_____

Patient Signature_____Date_____Provider Initials